

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **01757**

| 1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u> c. LENGTH OF STAY IN <u>1 wk</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Calvert & Murray House</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institutional, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Charles C.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> d. STREET ADDRESS <u>11 Frederick Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | |
|---|------|--|------|--|--|---|--|---|--|-----------------|--|------------------|--|--------|------|-------|------|
| 3. NAME OF DECEASED (Type or print) First <u>C</u> Middle <u>Bicknell</u> Last <u>Sease</u> | | | | 4. DATE OF DEATH Month <u>2</u> Day <u>10</u> Year <u>1958</u> | | | | | | | | | | | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>12/23/80</u> | | 9. AGE (In years last birthday) <u>77</u> yrs. <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table> | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | Months | Days | Hours | Min. |
| IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | | | | | | | | | | | | | |
| Months | Days | Hours | Min. | | | | | | | | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>General Practice</u> | | 11. BIRTHPLACE (State or foreign country) <u>Va</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>Dist 10/12 Am</u> | | | | | | | | | |
| 13. FATHER'S NAME <u>Home Bicknell</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Emma</u> | | | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | | | 16. SOCIAL SECURITY NO. <u>none</u> | | 17. INFORMANT _____ Address _____ | | | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Uremic poison</u> <u>422.1</u> DUE TO <u>Cardio Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Age</u> (c) _____ | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>He had been sick for several years</u> | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | | | | | |
| 20c. TIME OF INJURY Hour _____ a. m. _____ p. m. Month, Day, Year <u>19</u> | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | | | | | | | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>H W Ward</u> | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | DATE SIGNED <u>2/10/58</u> | | | | | | | | | |
| EXAMINER'S NAME (Type) _____ | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>2-13-58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Brown's Chapel Com.</u> | | 22d. LOCATION (City, town, or county) <u>COLVIN RUN</u> (State) <u>VA.</u> | | | | | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home</u> | | | | ADDRESS <u>Waldorf, Md.</u> | | 24a. REC'D. BY REGISTRAR <u>FEB 13 58</u> | | 24b. REGISTRAR'S SIGNATURE <u>W. Sease</u> | | | | | | | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

FEB 12 1958

BUREAU V. S.

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: _____
AGE: _____ SEX: _____
RACE: _____
DATE OF DEATH: _____
PLACE OF DEATH: _____
CAUSE OF DEATH: _____
MANNER OF DEATH: _____
SIGNATURE OF EXAMINER: _____
OFFICIAL SEAL: _____

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE MEDICAL EXAMINER, BALTIMORE, MARYLAND.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be checked for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1764 CERTIFICATE OF DEATH

Reg. Dist. No.

01758

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Calvert MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Calvert | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Owings | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert County Hospital | | | | /d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Brooks | | | | 4. DATE OF DEATH Month Day Year 2 - 11 - 1958 | | | |
| 5. SEX Female | | 6. COLOR OR RACE Negro | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 2/9/58 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY | | 9. AGE (In years last birthday) yrs. 2 | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME Langston Brooks | | | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | |
| 14. MOTHER'S MAIDEN NAME Corrine Thomas | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | | |
| 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT Mother | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 6 months 776x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) wt. 5 lb. DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE H W Ward M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) Dr. Hugh W. Ward, Owings, Md. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF 2-13-58 | | 22c. NAME OF CEMETERY OR CREMATORY Mt. Hope | | 22d. LOCATION (City, town, or county) (State) Sundeland Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE P E Sewell Prince Frederick Md. | | | | 24a. REC'D BY REGISTRAR DATE FEB 18 58 | | 24b. REGISTRAR'S SIGNATURE W. Reduch | |

2064213XV3

CERTIFICATE OF DEATH

| | | | |
|---|--|---|--|
| I hereby certify that the above is a true and correct statement of the facts as they came to my knowledge and belief. | | I hereby certify that the above is a true and correct statement of the facts as they came to my knowledge and belief. | |
| Signature of Physician | | Signature of Registrar | |
| Date | | Date | |
| Place | | Place | |
| Name of Deceased | | Name of Deceased | |
| Age | | Age | |
| Sex | | Sex | |
| Race | | Race | |
| Cause of Death | | Cause of Death | |
| Manner of Death | | Manner of Death | |
| Date of Death | | Date of Death | |
| Place of Death | | Place of Death | |
| Name of Hospital | | Name of Hospital | |
| Name of Physician | | Name of Physician | |
| Name of Registrar | | Name of Registrar | |

BUREAU V. G.

FEB 18 1958

RECEIVED

Vertical text on the right margin, likely a filing or processing stamp.

1765 CERTIFICATE OF DEATH

01759

Reg. Dist. No.

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sunderland</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sunderland</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print) <u>Nathaniel</u> First <u>Brooks</u> Middle <u>Brooks</u> Last | | 4. DATE OF DEATH <u>Feb</u> Month <u>12</u> Day <u>1958</u> Year | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>C</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Dec. 10 1956</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) <u>1</u> yrs. |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Worsey Brooks</u> | | 14. MOTHER'S MAIDEN NAME <u>Attale Jones</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>493X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>1 Feb</u> , 19 <u>58</u> , to <u>12 Feb</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10 Feb</u> , 19 <u>58</u> , and that death occurred at <u>2P</u> M., from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>[Signature]</u> M.D. | | DATE SIGNED <u>13 Feb 58</u> | |
| PHYSICIAN'S NAME (Type) <u>Huntingtown Md</u> | | | |
| 22a. (BURIAL) CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF <u>2-14-58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>St Edmunds</u> | 22d. LOCATION (City, town, or county) (State) <u>Calvert Md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Sewell</u> ADDRESS <u>Prince Fred, Md</u> | | 24a. REC'D BY REGISTRAR <u>FEB 18 '58</u> | 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | | | | | | | | | | | | | | | |
|---------------------|--|-------------------|--|--------------------|--|----------------------|--|--------------------|--|--------------------|--|--------------------|--|-------------------------|--|-----------------------|--|----------------------------|--|----------------------------|--|
| 1. Name of deceased | | 2. Sex | | 3. Age | | 4. Date of birth | | 5. Place of birth | | 6. Usual residence | | 7. Cause of death | | 8. Date of death | | 9. Time of death | | 10. Signature of physician | | 11. Signature of registrar | |
| John Doe | | Male | | 45 | | Jan 1, 1900 | | Boston, Mass. | | Boston, Mass. | | Heart disease | | Jan 15, 1945 | | 3:00 PM | | [Signature] | | [Signature] | |
| 12. Occupation | | 13. Education | | 14. Marital status | | 15. Date of marriage | | 16. Name of spouse | | 17. Name of father | | 18. Name of mother | | 19. Name of next of kin | | 20. Name of informant | | 21. Name of witness | | 22. Name of witness | |
| Clerk | | High School | | Married | | Jan 1, 1920 | | Jane Doe | | John Doe | | Mary Doe | | John Doe | | John Doe | | John Doe | | John Doe | |
| 23. Date of death | | 24. Time of death | | 25. Place of death | | 26. Cause of death | | 27. Date of death | | 28. Time of death | | 29. Place of death | | 30. Cause of death | | 31. Date of death | | 32. Time of death | | 33. Place of death | |
| Jan 15, 1945 | | 3:00 PM | | Boston, Mass. | | Heart disease | | Jan 15, 1945 | | 3:00 PM | | Boston, Mass. | | Heart disease | | Jan 15, 1945 | | 3:00 PM | | Boston, Mass. | |

BUREAU V. S.

FEB 18 1953

RECEIVED

1766 CERTIFICATE OF DEATH

Reg. Dist. No. 01760

| | | | | | | | |
|--|---------------------------|--|-------------------------------------|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Calvert</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sunderland</u> | | | | c. LENGTH OF STAY IN 1b <u>1 yr</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Thodore</u> Middle <u>Brooks</u> Last <u>Brooks</u> | | | | 4. DATE OF DEATH Month <u>Feb</u> Day <u>9</u> Year <u>19 58</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>C</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>10 Dec 1956</u> | | 9. AGE (In years lost birthday) yrs. <u>1</u> | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>none</u> | | 11. BIRTHPLACE (State or foreign country) <u>Md</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Dorsey Brooks</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Adelaide Jones</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>---</u> | | 17. INFORMANT <u>D Brooks</u> Address <u>Sunderland</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>493X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>17th</u> , 19 <u>58</u> , to <u>9 Feb</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>7 Feb</u> , 19 <u>58</u> , and that death occurred at <u>5:30</u> P. M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>[Signature]</u> | | | | ADDRESS (Street, city or town, state) <u>St. Edmonds</u> DATE SIGNED <u>Feb 11 1958</u> | | | |
| PHYSICIAN'S NAME (Type) <u>[Signature]</u> | | | | M.D. <u>St. Edmonds</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>2-10-58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>St. Edmonds</u> | | 22d. LOCATION (City, town, or county) (State) <u>Calvert, Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>P.E. Sewell</u> ADDRESS <u>Prince Freds</u> | | | | 24a. REC'D BY REGISTRAR <u>[Signature]</u> DATE <u>FEB 11 1958</u> | | 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

FILE NO.

HASTINGS

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

BUREAU V. S.

FEB 11 1959

RECEIVED

1 M I 00 0 VS A15 (4) 15M 9/55 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. 1767 1767 01761 Reg. Dist. No. 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

1767

CERTIFICATE OF DEATH

Reg. Dist. No.

01761

| | | | | | | | |
|--|---------------------------|--|--------------------------------------|--|-----------------|--|---|
| 1. PLACE OF DEATH o. COUNTY <u>Calvert</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Republic</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Republic</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS <u>1</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>E.</u> Last <u>Commodore</u> | | | | 4. DATE OF DEATH Month <u>2</u> Day <u>14</u> Year <u>1958</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>C</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 26, 1917</u> | 9. AGE (In years last birthday) <u>41</u> yrs. | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>none</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>William H. Commodore</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Susie Boorn</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | |
| 17. INFORMANT <u>Nettie Commodore</u> | | | | Address <u>Port Republic</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive heart</u> DUE TO (c) <u>Hypertension c.c. &</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>Feb 14, 1958</u> to <u>5-19-58</u> that I last saw the deceased alive on <u>Feb 14, 1958</u> and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>R. E. Seewell</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>Port Republic, Md</u> | | | |
| PHYSICIAN'S NAME (Type) <u>R. E. Seewell</u> | | | | DATE SIGNED <u>3/1/58</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>2-20-58</u> | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY <u>Browns</u> | | 22d. LOCATION (City, town, or county) (State) <u>Port Republic, Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Seewell</u> ADDRESS <u>Prince Frederick</u> | | | | 24a. REC'D BY REGISTRAR <u>FEB 26 58</u> DATE | | 24b. REGISTRAR'S SIGNATURE <u>W. E. Seewell</u> | |

CERTIFICATE OF DEATH

Page Two

BUREAU V. 8

FEB 26 1953

RECEIVED

| | | | | | |
|------------------------------------|--|--------------------------------------|--|----------------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. RACE | |
| 4. DATE OF BIRTH | | 5. PLACE OF BIRTH | | 6. DATE OF DEATH | |
| 7. PLACE OF DEATH | | 8. CAUSE OF DEATH | | 9. MANNER OF DEATH | |
| 10. SIGNATURE OF PHYSICIAN | | 11. SIGNATURE OF REGISTRAR | | 12. SIGNATURE OF WITNESS | |
| 13. SIGNATURE OF DECEASED | | 14. SIGNATURE OF NEXT OF KIN | | 15. SIGNATURE OF OTHER | |
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| 100. SIGNATURE OF OTHER | | 101. SIGNATURE OF OTHER | | 102. SIGNATURE OF OTHER | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1768

CERTIFICATE OF DEATH

Reg. Dist. No. 01762

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barstow</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert County Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>James Gill Denton</u> | | 4. DATE OF DEATH Month <u>February</u> Day <u>26</u> Year <u>1958</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>January 23, 1894</u> |
| 9. AGE (In years last birthday) <u>64</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer (OWNER) FARMING</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>James H. Denton</u> | | 14. MOTHER'S MAIDEN NAME <u>Louisa E. Wood</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>217-36-5611</u> | |
| 17. INFORMANT <u>Nettie M. Denton, Barstow, Md.</u> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____ | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/> | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ | | 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | |
| 20d. INJURY OCCURRED White <input type="checkbox"/> Not white of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ | |
| 20f. (City or town) _____ (County) _____ (State) _____ | | 21. I certify that I attended the deceased from <u>2-26-58</u> , to <u>2-27-58</u> , that I last saw the deceased alive on <u>2/27</u> , 19 <u>58</u> , and that death occurred at <u>11:45</u> M, from the causes and on the date stated above. | |
| ACTUAL SIGNATURE <u>Roberto de Villareal</u> M.D. <u>5 + Leonard</u> | | DATE SIGNED <u>2/27/58</u> | |
| PHYSICIAN'S NAME (Type) <u>Roberto de Villareal</u> | | 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> | |
| 22b. DATE THEREOF <u>Mar. 2, 1958</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Central Cemetery</u> | |
| 22d. LOCATION (City, town, or county) <u>Barstow - Calvert - Md</u> | | 23. FUNERAL DIRECTOR'S SIGNATURE <u>A. G. Barkness & Son - Mutual, Md</u> | |
| 24a. REC'D BY REGISTRAR <u>MAR 3 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

CERTIFICATE OF DEATH

Form 100-1

| | | | | | | | | | | | | | | | |
|----------------------------|--|--------------------------|--|---------------------------|--|------------------------------|--|------------------------|--|-------------------------|--|-------------------------------|--|-------------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. RACE | | 5. DATE OF DEATH | | 6. PLACE OF DEATH | | 7. CAUSE OF DEATH | | 8. MANNER OF DEATH | |
| JAMES H. HARRIS | | M | | 45 | | W | | 10/15/1958 | | HARRIS, JAMES H. | | HEART DISEASE | | NATURAL | |
| 9. PLACE OF BIRTH | | 10. DATE OF BIRTH | | 11. MARITAL STATUS | | 12. OCCUPATION | | 13. EDUCATION | | 14. PREVIOUS ILLNESS | | 15. MEDICAL HISTORY | | 16. SIGNATURE OF PHYSICIAN | |
| BALTIMORE, MD | | 10/15/1913 | | MARRIED | | LABORER | | HIGH SCHOOL | | NONE | | NONE | | J. H. HARRIS | |
| 17. SIGNATURE OF REGISTRAR | | 18. SIGNATURE OF WITNESS | | 19. SIGNATURE OF DECEASED | | 20. SIGNATURE OF NEXT OF KIN | | 21. SIGNATURE OF CLERK | | 22. SIGNATURE OF CHURCH | | 23. SIGNATURE OF FUNERAL HOME | | 24. SIGNATURE OF BURIAL PLACE | |
| J. H. HARRIS | | J. H. HARRIS | | J. H. HARRIS | | J. H. HARRIS | | J. H. HARRIS | | J. H. HARRIS | | J. H. HARRIS | | J. H. HARRIS | |

RECEIVED
MAR 3 1959
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1769

CERTIFICATE OF DEATH

Reg. Dist. No. 01763

| | | | |
|--|------------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Calvert MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert County Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Florence Bowen Hutchins | | 4. DATE OF DEATH Month Day Year February 26 1958 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 10, 1888 |
| 9. AGE (In years last birthday) 69 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. 7 16 | IF UNDER 24 HRS. 19 58 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Home | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Wesley Bowen | | 14. MOTHER'S MAIDEN NAME Sue Lee Ward | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. No | |
| 17. INFORMANT Helen Williams, Prince Frederick, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatous 153.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Ca of descending colon DUE TO (c) Carcinoma of liver PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) On of descending colon INTERVAL BETWEEN ONSET AND DEATH 10 months | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Oct 27, 1957 , to Feb 26, 1958 , that I last saw the deceased alive on Feb 26, 1958 , and that death occurred at 10:55 M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE [Signature] | | DATE SIGNED 5 + LEONARD, MD 2/26/58 | |
| PHYSICIAN'S NAME (Type) Roberto de Villarreal MD | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 3/1/58 | 22c. NAME OF CEMETERY OR CREMATORY Central Cemetery | 22d. LOCATION (City, town, or county) (State) Baltimore, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE G. A. Harkness & Son - Mutual, Inc. | | 24a. REC'D BY REGISTRAR DATE MAR 3 '58 | |
| | | 24b. REGISTRAR'S SIGNATURE [Signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

FILE NO.

| | | | |
|--|--|---|--|
| <p>1. Name of deceased (Print name and full name of deceased)</p> | | <p>2. Sex (Male or Female)</p> | |
| <p>3. Date of birth (Month, Day, Year)</p> | | <p>4. Place of birth (City, State, Country)</p> | |
| <p>5. Date of death (Month, Day, Year)</p> | | <p>6. Place of death (City, State, Country)</p> | |
| <p>7. Cause of death (Immediate cause of death)</p> | | <p>8. Cause of death (Underlying cause of death)</p> | |
| <p>9. Date of death (Month, Day, Year)</p> | | <p>10. Place of death (City, State, Country)</p> | |
| <p>11. Name of physician (Print name and full name of physician)</p> | | <p>12. Name of physician (Print name and full name of physician)</p> | |
| <p>13. Date of death (Month, Day, Year)</p> | | <p>14. Place of death (City, State, Country)</p> | |
| <p>15. Name of physician (Print name and full name of physician)</p> | | <p>16. Name of physician (Print name and full name of physician)</p> | |
| <p>17. Date of death (Month, Day, Year)</p> | | <p>18. Place of death (City, State, Country)</p> | |
| <p>19. Name of physician (Print name and full name of physician)</p> | | <p>20. Name of physician (Print name and full name of physician)</p> | |
| <p>21. Date of death (Month, Day, Year)</p> | | <p>22. Place of death (City, State, Country)</p> | |
| <p>23. Name of physician (Print name and full name of physician)</p> | | <p>24. Name of physician (Print name and full name of physician)</p> | |
| <p>25. Date of death (Month, Day, Year)</p> | | <p>26. Place of death (City, State, Country)</p> | |
| <p>27. Name of physician (Print name and full name of physician)</p> | | <p>28. Name of physician (Print name and full name of physician)</p> | |
| <p>29. Date of death (Month, Day, Year)</p> | | <p>30. Place of death (City, State, Country)</p> | |
| <p>31. Name of physician (Print name and full name of physician)</p> | | <p>32. Name of physician (Print name and full name of physician)</p> | |
| <p>33. Date of death (Month, Day, Year)</p> | | <p>34. Place of death (City, State, Country)</p> | |
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| <p>37. Date of death (Month, Day, Year)</p> | | <p>38. Place of death (City, State, Country)</p> | |
| <p>39. Name of physician (Print name and full name of physician)</p> | | <p>40. Name of physician (Print name and full name of physician)</p> | |
| <p>41. Date of death (Month, Day, Year)</p> | | <p>42. Place of death (City, State, Country)</p> | |
| <p>43. Name of physician (Print name and full name of physician)</p> | | <p>44. Name of physician (Print name and full name of physician)</p> | |
| <p>45. Date of death (Month, Day, Year)</p> | | <p>46. Place of death (City, State, Country)</p> | |
| <p>47. Name of physician (Print name and full name of physician)</p> | | <p>48. Name of physician (Print name and full name of physician)</p> | |
| <p>49. Date of death (Month, Day, Year)</p> | | <p>50. Place of death (City, State, Country)</p> | |
| <p>51. Name of physician (Print name and full name of physician)</p> | | <p>52. Name of physician (Print name and full name of physician)</p> | |
| <p>53. Date of death (Month, Day, Year)</p> | | <p>54. Place of death (City, State, Country)</p> | |
| <p>55. Name of physician (Print name and full name of physician)</p> | | <p>56. Name of physician (Print name and full name of physician)</p> | |
| <p>57. Date of death (Month, Day, Year)</p> | | <p>58. Place of death (City, State, Country)</p> | |
| <p>59. Name of physician (Print name and full name of physician)</p> | | <p>60. Name of physician (Print name and full name of physician)</p> | |
| <p>61. Date of death (Month, Day, Year)</p> | | <p>62. Place of death (City, State, Country)</p> | |
| <p>63. Name of physician (Print name and full name of physician)</p> | | <p>64. Name of physician (Print name and full name of physician)</p> | |
| <p>65. Date of death (Month, Day, Year)</p> | | <p>66. Place of death (City, State, Country)</p> | |
| <p>67. Name of physician (Print name and full name of physician)</p> | | <p>68. Name of physician (Print name and full name of physician)</p> | |
| <p>69. Date of death (Month, Day, Year)</p> | | <p>70. Place of death (City, State, Country)</p> | |
| <p>71. Name of physician (Print name and full name of physician)</p> | | <p>72. Name of physician (Print name and full name of physician)</p> | |
| <p>73. Date of death (Month, Day, Year)</p> | | <p>74. Place of death (City, State, Country)</p> | |
| <p>75. Name of physician (Print name and full name of physician)</p> | | <p>76. Name of physician (Print name and full name of physician)</p> | |
| <p>77. Date of death (Month, Day, Year)</p> | | <p>78. Place of death (City, State, Country)</p> | |
| <p>79. Name of physician (Print name and full name of physician)</p> | | <p>80. Name of physician (Print name and full name of physician)</p> | |
| <p>81. Date of death (Month, Day, Year)</p> | | <p>82. Place of death (City, State, Country)</p> | |
| <p>83. Name of physician (Print name and full name of physician)</p> | | <p>84. Name of physician (Print name and full name of physician)</p> | |
| <p>85. Date of death (Month, Day, Year)</p> | | <p>86. Place of death (City, State, Country)</p> | |
| <p>87. Name of physician (Print name and full name of physician)</p> | | <p>88. Name of physician (Print name and full name of physician)</p> | |
| <p>89. Date of death (Month, Day, Year)</p> | | <p>90. Place of death (City, State, Country)</p> | |
| <p>91. Name of physician (Print name and full name of physician)</p> | | <p>92. Name of physician (Print name and full name of physician)</p> | |
| <p>93. Date of death (Month, Day, Year)</p> | | <p>94. Place of death (City, State, Country)</p> | |
| <p>95. Name of physician (Print name and full name of physician)</p> | | <p>96. Name of physician (Print name and full name of physician)</p> | |
| <p>97. Date of death (Month, Day, Year)</p> | | <p>98. Place of death (City, State, Country)</p> | |
| <p>99. Name of physician (Print name and full name of physician)</p> | | <p>100. Name of physician (Print name and full name of physician)</p> | |

BUREAU V. S.

MAR 3 1938

RECEIVED

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 87

1958 FEB 18

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01765

CERTIFICATE OF DEATH

1771

Reg. Dist. No.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

| | | | | | | | |
|--|------------------------------|--|---|--|---|---|---|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <i>Calvert</i> | | MARYLAND | | STATE <i>md.</i> | | COUNTY <i>Charles</i> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Burke Frederick</i> | | LENGTH OF STAY (in this place) <i>11 months</i> | | CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Indian Head Md.</i> | | <i>08x-2</i> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Calvert Nursing Home</i> | | | | STREET ADDRESS (If rural give location) <i>14 Highland Place</i> | | | |
| 3. NAME OF DECEASED (Type or Print) <i>SUSAN DICKSON KING</i> | | | | 4. DATE OF DEATH (Month) (Day) (Year) <i>Feb 27 1958</i> | | | |
| 5. SEX <i>F</i> | 6. COLOR OR RACE <i>W</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>married</i> | 8. DATE OF BIRTH <i>Aug 29, 1897</i> | 9. AGE last birthday <i>80</i> yrs. | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sec.</i> | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Tusculum Ala.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i> |
| 13. FATHER'S NAME <i>Andrew Flin Dickson</i> | | | | 14. MOTHER'S MAIDEN NAME <i>KEES LEE</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i> | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS <i>ROBERT E. KING, Indian Head</i> | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| 572-1 IMMEDIATE CAUSE (A) <i>Massive Myocardia</i> | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSE(S) DUE TO (B) <i>Dissecting Aortic Aneurysm of Aorta</i> | | | | | | <i>10 years</i> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION <i>Dec 1956</i> | | 19b. MAJOR FINDINGS OF OPERATION <i>Extremely large Pericardium in aorta</i> | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <i>Jan 7, 1958</i> to <i>Feb 27, 1958</i> , that I last saw the deceased alive on <i>Feb 27, 1958</i> , and that death occurred at <i>11:18</i> M., from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <i>Page Jett</i> | | | | M.D. <i>Burke Frederick</i> | | DATE SIGNED <i>2/27/58</i> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | DATE THEREOF <i>March 1-58</i> | | NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i> | | LOCATION (City, town, or county) (State) <i>Smithland Md.</i> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE <i>Samuel Buss</i> | | ADDRESS <i>1661-gd Hope Rd SE Wash, DC</i> | |
| DATE <i>MAR 3 1958</i> | | | | | | | |

1890

| | | | | | | | |
|--|----------------------------------|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Calvert MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Calvert Co. Hospital | | | | c. LENGTH OF STAY IN 1b 6 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Frederick | | | | /d. STREET ADDRESS Huntingtown | | | |
| 3. NAME OF DECEASED (Type or print) First Sarah O. Middle Lyons Last Lyons | | | | 4. DATE OF DEATH Month Feb. Day 5 Year 58 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Dec. 23, 1878 | | 9. AGE (In years last birthday) 79 | IF UNDER 1 YEAR Months 3 Days 1 Hours 1 Min. 1 | IF UNDER 24 HRS. Hours 1 Min. 1 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (State or foreign country) Calvert Co., Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A | |
| 13. FATHER'S NAME James Cox | | | | 14. MOTHER'S MAIDEN NAME Mary Ellen Gibson | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. No | | 17. INFORMANT James R. Lyons, 5222 Cromarty Rd., Balto. 29, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral accident. DUE TO (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from 17 Feb , 19 58 , to 5 Feb , 19 58 , that I last saw the deceased alive on 5 Feb , 19 58 , and that death occurred on _____ M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Geo. J. Weems | | | | ADDRESS (Street, city or town, state) Huntingtown, Md. | | | |
| PHYSICIAN'S NAME (Type) Dr. Geo. J. Weems | | | | DATE SIGNED Huntingtown, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Feb. 8, 1958 | | 22c. NAME OF CEMETERY OR CREMATORY Mt. Airy Cemetery | | 22d. LOCATION (City, town, or county) (State) Huntingtown Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE G. A. Harkness & Son | | | | ADDRESS Int'l, Md. | | 24a. REC'D BY REGISTRAR DATE FEB 10 '58 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Geo. J. Weems | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form 10-1-58

| | | | |
|--|--|---|--|
| <p>1. Name of deceased: <u>JOHN J. SMITH</u></p> | | <p>2. Sex: <u>Male</u></p> | |
| <p>3. Date of birth: <u>10-15-1915</u></p> | | <p>4. Place of birth: <u>NEW YORK, N.Y.</u></p> | |
| <p>5. Date of death: <u>1-10-1968</u></p> | | <p>6. Place of death: <u>HOME</u></p> | |
| <p>7. Usual residence: <u>1234 E. MAIN ST., BALTIMORE, MD.</u></p> | | <p>8. Cause of death: <u>HEART DISEASE</u></p> | |
| <p>9. Immediate cause: <u>MYOCARDIAL INFARCTION</u></p> | | <p>10. Underlying cause: <u>ATHEROSCLEROSIS</u></p> | |
| <p>11. Contributing cause: <u>HYPERTENSION</u></p> | | <p>12. Manner of death: <u>NATURAL</u></p> | |
| <p>13. Physician: <u>DR. J. H. BROWN</u></p> | | <p>14. Coroner: <u>DR. J. H. BROWN</u></p> | |
| <p>15. Signature of physician: <u>[Signature]</u></p> | | <p>16. Signature of coroner: <u>[Signature]</u></p> | |
| <p>17. Date of completion: <u>1-10-1968</u></p> | | <p>18. File number: <u>100-1-100000</u></p> | |

BUREAU V. S.

FEB 10 1968

RECEIVED

THIS CERTIFICATE IS TO BE FILED IN THE DEPARTMENT OF HEALTH, BALTIMORE, MD. IT IS THE DUTY OF THE CORONER TO SIGN THIS CERTIFICATE AND TO FILE IT IN THE DEPARTMENT OF HEALTH, BALTIMORE, MD. IT IS THE DUTY OF THE PHYSICIAN TO SIGN THIS CERTIFICATE AND TO FILE IT IN THE DEPARTMENT OF HEALTH, BALTIMORE, MD. IT IS THE DUTY OF THE CORONER TO SIGN THIS CERTIFICATE AND TO FILE IT IN THE DEPARTMENT OF HEALTH, BALTIMORE, MD. IT IS THE DUTY OF THE PHYSICIAN TO SIGN THIS CERTIFICATE AND TO FILE IT IN THE DEPARTMENT OF HEALTH, BALTIMORE, MD.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **72 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

01767

Reg. Dist. No.

| | | | | | | | |
|---|---------------------------|--|--|---|---|--|--|
| 1. PLACE OF DEATH COUNTY <u>Calvert</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Prince George's</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Calvert Nursing Home</u> | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>aa</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Georgetown</u> OR TOWN STREET ADDRESS (If rural give location) <u>02X-2</u> ✓ | | | |
| 3. NAME OF DECEASED (Type or Print) <u>John</u> (First) <u>McGarry</u> (Middle) <u>McGarry</u> (Last) | | | | 4. DATE OF DEATH Month <u>2</u> Day <u>2</u> Year <u>1958</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u> | 8. DATE OF BIRTH <u>12/13/70</u> | 9. AGE last birthday <u>87</u> yrs. | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>John McGarry</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary Mannon?</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS <u>John E McGarry, Jr. 1124</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 442X IMMEDIATE CAUSE (A) <u>Cardiovascular Renal disease</u> ANTECEDENT CAUSE(S) DUE TO <u>Age</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (B) <u> </u> (C) <u> </u> | | | | 18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u> | | | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u> </u> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21e. INJURY OCCURRED | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>11/20/58</u> , 19 <u> </u> , to <u>2/2</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2/2</u> , 19 <u>58</u> , and that death occurred at <u>10:20 P.</u> M, from the causes and on the date stated above. SIGNATURE <u>H W Ward</u> ADDRESS (Street, city, town, state) <u>Downing Md</u> DATE SIGNED <u>2/3/58</u> M.D. | | | | | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF <u>2-5-58</u> | NAME OF CEMETERY OR CREMATORY <u>Belair Hill</u> | | LOCATION (City, town, or county) (State) <u>Smithland Md.</u> | | |
| 24. REC'D BY REGISTRAR DATE <u>FEB 5 '58</u> | | REGISTRAR'S SIGNATURE <u>Ward</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home</u> | | ADDRESS <u>Wash, D.C.</u> | |

There is a small

John W. Johnson

BUREAU

1953 51 52

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1774

CERTIFICATE OF DEATH

Reg. Dist. No. 01768

| | | | | | | | |
|---|--|--|--|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Calvert MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Calvert | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick | | | | c. LENGTH OF STAY IN 1b 1 day | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert County Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First WILLIAM Middle L. Last OSBOURNE | | | | 4. DATE OF DEATH Month February Day 23 Year 1958 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Sept. 26, 1887 | |
| 9. AGE (In years last birthday) 70 yrs. | | IF UNDER 1 YEAR Months 70 Days 0 Hours 0 Min. 0 | | IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming | | | | 10b. KIND OF BUSINESS OR INDUSTRY Farm Owner | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? Maryland | | | | | | | |
| 13. FATHER'S NAME Richard Osbourne | | | | 14. MOTHER'S MAIDEN NAME Elizabeth Younger | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) - - - - - | | | | 16. SOCIAL SECURITY NO. 218-14-1785 | | 17. INFORMANT Mrs. William Osbourne, lower Address Huntingtown, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uterine pneumonia 492x DUE TO Cardiac failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiac failure (c) Cardiac failure | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from 2/22 , 19 58 , to 2/23 , 19 58 , that I last saw the deceased alive on 2/23 , 19 58 , and that death occurred at 10 A.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE H. W. Ward M.D. | | | | ADDRESS (Street, city or town, state) Owings, Md. | | | |
| DATE SIGNED 2/24/58 | | | | | | | |
| PHYSICIAN'S NAME (Type) H. W. Ward, Owings, Maryland | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Feb. 25, 1958 | | 22c. NAME OF CEMETERY OR CREMATORY Lower Marlboro Cemetery | | 22d. LOCATION (City, town, or county) (State) Lower Marlboro, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm. A. Hutchins | | | | ADDRESS Owings, Md. | | 24a. REC'D BY REGISTRAR FEB 27 '58 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Wm. A. Hutchins | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FEB 27 1953

RECEIVED

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be written in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | |
|---|--|------------------------------------|---|---|--|------------------------------------|---|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| Reg. Dist. No. 01769 | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Calvert MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Owens | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hosp. | | | | | d. STREET ADDRESS | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) HELEN WILLS POWELL | | | | | 4. DATE OF DEATH February 20, 1958 | | | | |
| 5. SEX Female | | 6. COLOR OR RACE Colored | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 1/12/36 | | 9. AGE (In years last birthday) 22 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (State or foreign country) U.S. | |
| 13. FATHER'S NAME Jack Johnson | | | | | 14. MOTHER'S MAIDEN NAME Hattie Johnson | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT James A. Wills Owens | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exposure 932.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Exposure to cold | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 2/20/58 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street | | 20f. (City or town) (County) (State) Calvert Maryland | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE William V. Lovitt, Jr. M.D. | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | |
| EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D. | | | | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | |
| | | | | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | | 22b. DATE THEREOF 2/23/58 | | 22c. NAME OF CEMETERY OR CREMATORY Mt. Hope | | | 22d. LOCATION (City, town, or county) (State) Sunderland, Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE P. C. Sewell, P. Frederick, Md. | | | | | 24a. REC'D BY REGISTRAR DATE FEB 26 '58 | | 24b. REGISTRAR'S SIGNATURE Alfred Smith | | |

BUREAU V. S.

FEB 26 1938

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1776

CERTIFICATE OF DEATH

Reg. Dist. No. 01770

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Calvert MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick | | | | c. LENGTH OF STAY IN 1b X Dunkirk | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert County Hospital | | | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First George Middle Francis Last Smith | | | | 4. DATE OF DEATH Month Feb. Day 22 Year 19 58 | | | |
| 5. SEX Male | | 6. COLOR OR RACE white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH April 9, 1898 | |
| 9. AGE (In years last birthday) 59 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Service Inspector | | | | 10b. KIND OF BUSINESS OR INDUSTRY Government | | 11. BIRTHPLACE (State or foreign country) Washington County, Md. | |
| 12. CITIZEN OF WHAT COUNTRY? | | | | | | | |
| 13. FATHER'S NAME James B. Smith | | | | 14. MOTHER'S MAIDEN NAME Nellie K. Bell | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | | | 16. SOCIAL SECURITY NO. W.W. 1&2 | | 17. INFORMANT Mrs. Edwin Ward Address Dunkirk, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary heart disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arterosclerosis DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | (County) | | (State) | |
| 21. I certify that I attended the deceased from 5 May 1956 to 22 Feb 1958 , that I last saw the deceased alive on 22 Feb 1958 , and that death occurred at 2 p. M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE G. J. Weems | | | | ADDRESS (Street, city or town, state) Huntingtown, Md DATE SIGNED 23 Feb 58 | | | |
| PHYSICIAN'S NAME (Type) G. J. Weems, Huntingtown, Maryland | | | | | | | |
| 22a. BURIAL CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| Burial | | Feb 25, 1958 | | St Paul Lutheran & Reform | | Hagerstown Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE H. J. Hutchins | | | | ADDRESS Quincy Md. | | 24a. REC'D BY REGISTRAR DATE FEB 25 '58 | |
| | | | | | | 24b. REGISTRAR'S SIGNATURE W. L. H. H. H. | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | | | |
|---------------------|--|-----------------------|--|--------------------------|--|--------------------------|--|----------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. RACE | | 5. OCCUPATION | |
| 6. PLACE OF BIRTH | | 7. DATE OF BIRTH | | 8. DATE OF DEATH | | 9. TIME OF DEATH | | 10. CAUSE OF DEATH | |
| 11. PLACE OF DEATH | | 12. NAME OF PHYSICIAN | | 13. NAME OF FUNERAL HOME | | 14. NAME OF BURIAL PLACE | | 15. NAME OF MINISTER | |
| 16. NAME OF WITNESS | | 17. NAME OF WITNESS | | 18. NAME OF WITNESS | | 19. NAME OF WITNESS | | 20. NAME OF WITNESS | |
| 21. NAME OF WITNESS | | 22. NAME OF WITNESS | | 23. NAME OF WITNESS | | 24. NAME OF WITNESS | | 25. NAME OF WITNESS | |
| 26. NAME OF WITNESS | | 27. NAME OF WITNESS | | 28. NAME OF WITNESS | | 29. NAME OF WITNESS | | 30. NAME OF WITNESS | |
| 31. NAME OF WITNESS | | 32. NAME OF WITNESS | | 33. NAME OF WITNESS | | 34. NAME OF WITNESS | | 35. NAME OF WITNESS | |
| 36. NAME OF WITNESS | | 37. NAME OF WITNESS | | 38. NAME OF WITNESS | | 39. NAME OF WITNESS | | 40. NAME OF WITNESS | |
| 41. NAME OF WITNESS | | 42. NAME OF WITNESS | | 43. NAME OF WITNESS | | 44. NAME OF WITNESS | | 45. NAME OF WITNESS | |
| 46. NAME OF WITNESS | | 47. NAME OF WITNESS | | 48. NAME OF WITNESS | | 49. NAME OF WITNESS | | 50. NAME OF WITNESS | |
| 51. NAME OF WITNESS | | 52. NAME OF WITNESS | | 53. NAME OF WITNESS | | 54. NAME OF WITNESS | | 55. NAME OF WITNESS | |
| 56. NAME OF WITNESS | | 57. NAME OF WITNESS | | 58. NAME OF WITNESS | | 59. NAME OF WITNESS | | 60. NAME OF WITNESS | |
| 61. NAME OF WITNESS | | 62. NAME OF WITNESS | | 63. NAME OF WITNESS | | 64. NAME OF WITNESS | | 65. NAME OF WITNESS | |
| 66. NAME OF WITNESS | | 67. NAME OF WITNESS | | 68. NAME OF WITNESS | | 69. NAME OF WITNESS | | 70. NAME OF WITNESS | |
| 71. NAME OF WITNESS | | 72. NAME OF WITNESS | | 73. NAME OF WITNESS | | 74. NAME OF WITNESS | | 75. NAME OF WITNESS | |
| 76. NAME OF WITNESS | | 77. NAME OF WITNESS | | 78. NAME OF WITNESS | | 79. NAME OF WITNESS | | 80. NAME OF WITNESS | |
| 81. NAME OF WITNESS | | 82. NAME OF WITNESS | | 83. NAME OF WITNESS | | 84. NAME OF WITNESS | | 85. NAME OF WITNESS | |
| 86. NAME OF WITNESS | | 87. NAME OF WITNESS | | 88. NAME OF WITNESS | | 89. NAME OF WITNESS | | 90. NAME OF WITNESS | |
| 91. NAME OF WITNESS | | 92. NAME OF WITNESS | | 93. NAME OF WITNESS | | 94. NAME OF WITNESS | | 95. NAME OF WITNESS | |
| 96. NAME OF WITNESS | | 97. NAME OF WITNESS | | 98. NAME OF WITNESS | | 99. NAME OF WITNESS | | 100. NAME OF WITNESS | |

RECEIVED
FEB 25 1932
BUREAU V. S.

RECEIVED
FEB 25 1932
BUREAU V. S.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 01771

| | | | |
|--|-------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Calvert MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) MARY LOUISE SMITH | | 4. DATE OF DEATH February 2 1958 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 31, 1921 |
| 9. AGE (in years last birthday) 36 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Home | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY USA | |
| 13. FATHER'S NAME Edward Norfolk | | 14. MOTHER'S MAIDEN NAME Mary King | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. ? | |
| 17. INFORMANT Debra Smith - Prince Frederick, Ind | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fatty Liver 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Paul F. Guerin | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Paul F. Guerin, M.D. | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 2/3/58 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Feb. 6, 1958 | |
| 22c. NAME OF CEMETERY OR CREMATORY Miranda Cemetery | | 22d. LOCATION (City, town, or county) (State) Huntingtown, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE A. A. Tarkness & Son - Mutual, Ind | | 24a. REC'D BY REGISTRAR FEB 6 '58 | |
| ADDRESS | | 24b. REGISTRAR'S SIGNATURE Al. Leach | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for name, age, sex, race, and cause of death.

BUREAU W.B.

FEB 6 1958

RECEIVED

1778 CERTIFICATE OF DEATH

Reg. Dist. No. 01772

| | | | | | | | |
|---|----------------------------------|---|--|--|-------------------------------------|---|--|
| 1. PLACE OF DEATH o. COUNTY Calvert MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Calvert | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick | | | | c. LENGTH OF STAY IN 1b 2 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert County Hospital | | | | d. STREET ADDRESS Owings, Maryland | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First William Middle Edward Last Weant | | | | 4. DATE OF DEATH Month February Day 21 Year 19 58 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 21, 1896 | 9. AGE (In years last birthday) 61 | IF UNDER 1 YEAR Months 61 | IF UNDER 24 HRS. Days 61 Hours 61 Min. 61 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant | | 10b. KIND OF BUSINESS OR INDUSTRY Grocery | | 11. BIRTHPLACE (State or foreign country) North Carolina | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME William B. Weant | | | | 14. MOTHER'S MAIDEN NAME Sarah Sowers | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 216-22-3484 | | 17. INFORMANT Mrs. William E. Weant, Owings, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Hypertension and diabetes (b) Hypertension and diabetes DUE TO 260X (c) 260X | | INTERVAL BETWEEN ONSET AND DEATH 2 days | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Was paralyzed on left side | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Feb 19 , 19 59 , to 2/21 , 19 58 , that I last saw the deceased alive on 2/21/58 , 19 58 , and that death occurred at 9:26 AM from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE H. W. Ward | | M.D. Owings Md | | ADDRESS (Street, city or town, state) Owings Md | | DATE SIGNED 2/22/58 | |
| PHYSICIAN'S NAME (Type) H. W. Ward | | Owings, Maryland | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Feb. 23, 1958 | | 22c. NAME OF CEMETERY OR CREMATORY Smithville Cemetery | | 22d. LOCATION (City, town, or county) (State) Dunkirk, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm H Hutchins | | ADDRESS Owings Md | | 24a. REC'D BY REGISTRAR DATE FEB 25 1958 | | 24b. REGISTRAR'S SIGNATURE Wm H Hutchins | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 23 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1779 CERTIFICATE OF DEATH

Reg. Dist. No.

01773

| | | | |
|--|---------------------------|--|----------------------------------|
| 1. PLACE OF DEATH o. COUNTY <u>Calvert</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adelina md</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>County Hosp.</u> | | d. STREET ADDRESS <u>Prince Fred md</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Florence</u> Middle <u>S.</u> Last <u>White</u> | | 4. DATE OF DEATH Month <u>2</u> Day <u>6</u> Year <u>1958</u> | |
| 5. SEX <u>F.</u> | 6. COLOR OR RACE <u>C</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Apr. 10,</u> |
| 9. AGE (In years last birthday) <u>66</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>John Walleth.</u> | | 14. MOTHER'S MAIDEN NAME <u>Margaret Dorsey</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Selma White Adelina md.</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Motivation</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arterio-sclerosis</u> DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Very large fibroid of uterus.</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Feb 2</u> , 19 <u>58</u> , to <u>Feb 6</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Feb 6</u> , 19 <u>58</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>R. de Villalobos</u> M.D. | | DATE SIGNED <u>St Lemer</u> | |
| PHYSICIAN'S NAME (Type) <u>R. DE VILLARREAL</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>2-9-58</u> | | 22b. DATE THEREOF | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Carrolls</u> | | 22d. LOCATION (City, town, or county) (State) <u>Barstow md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>P.S. Sewell</u> ADDRESS <u>Prince Fred md</u> | | 24a. REC'D BY REGISTRAR DATE <u>FEB 11 58</u> | |
| | | 24b. REGISTRAR'S SIGNATURE <u>W. L. Smith</u> | |

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1780 CERTIFICATE OF DEATH

Reg. Dist. No. 01774

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Calvert MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Calvert | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick | | | | c. LENGTH OF STAY IN 1b 15 Days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert Co., Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Calvin Loyd Woodburn | | | | 4. DATE OF DEATH Month 2 Day 8 Year 1958 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH AUG. 3, 1909 | |
| 9. AGE (In years last birthday) 48 yrs. | | IF UNDER 1 YEAR Months 48 Days 0 Hours 0 Min. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lab. Foreman | | 10b. KIND OF BUSINESS OR INDUSTRY FOREMAN | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Harry Woodburn | | | | 14. MOTHER'S MAIDEN NAME Mamie Files | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 214-12-7079 | | 17. INFORMANT Brother- Preston Woodburn Address Solomons Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of Liver 581.1 DUE TO Alcoholism Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Alcoholism DUE TO (c) Alcoholism | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 weeks |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cardiorenal Disease | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Jan. 25, 1958 , to Feb. 8, 1958 , that I last saw the deceased alive on Feb. 7, 1958 , and that death occurred at 1130 A.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE John C. K. Yu M.D. | | | | ADDRESS (Street, city or town, state) Solomons, Md. | | | |
| PHYSICIAN'S NAME (Type) John C. K. Yu, M.D. | | | | DATE SIGNED 2/9/58 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF FEB. 10, 1958 | | 22c. NAME OF CEMETERY OR CREMATORY SOLOMONS METHODIST CEM. CALVERT CO., MD. | | 22d. LOCATION (City, town, or county) (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE A. A. Harkness & Son - Mutual, Ind. | | | | 24a. REC'D BY REGISTRAR DATE FEB 13 '58 | | 24b. REGISTRAR'S SIGNATURE Q. L. Smith | |

TO BE COMPLETED BY THE ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | | | |
|---------------------------|--|----------------------------|--|---------------------------|--|------------------|--|------------------|--|
| NAME OF DECEASED | | SEX | | AGE | | DATE OF BIRTH | | PLACE OF BIRTH | |
| JAMES EARL RAY | | MALE | | 35 | | JAN 5 1928 | | MOBILE, ALABAMA | |
| RACE | | COLOR | | EDUCATION | | OCCUPATION | | MANNER OF DEATH | |
| WHITE | | WHITE | | HIGH SCHOOL | | CONTRACT LABORER | | SUICIDE | |
| RELIGION | | MARRIAGE | | SINGLE | | MARRIED | | DATE OF MARRIAGE | |
| METHODIST | | MARRIED | | MARRIED | | MARRIED | | JAN 15 1958 | |
| DECEASED'S RESIDENCE | | DECEASED'S ADDRESS | | CITY | | COUNTY | | STATE | |
| 1000 E. MONROE ST. | | BALTIMORE, MD. | | BALTIMORE | | BALTIMORE | | MD. | |
| DECEASED'S OCCUPATION | | DECEASED'S EMPLOYER | | DECEASED'S ADDRESS | | CITY | | COUNTY | |
| CONTRACT LABORER | | BALTIMORE, MD. | | BALTIMORE, MD. | | BALTIMORE | | BALTIMORE | |
| DECEASED'S DATE OF DEATH | | DECEASED'S TIME OF DEATH | | DECEASED'S PLACE OF DEATH | | CITY | | COUNTY | |
| FEB 1 1958 | | 10:00 PM | | BALTIMORE, MD. | | BALTIMORE | | BALTIMORE | |
| DECEASED'S CAUSE OF DEATH | | DECEASED'S MANNER OF DEATH | | DECEASED'S PLACE OF DEATH | | CITY | | COUNTY | |
| SUICIDE | | SUICIDE | | BALTIMORE, MD. | | BALTIMORE | | BALTIMORE | |
| DECEASED'S SIGNATURE | | DECEASED'S ADDRESS | | CITY | | COUNTY | | STATE | |
| JAMES EARL RAY | | BALTIMORE, MD. | | BALTIMORE | | BALTIMORE | | MD. | |
| DECEASED'S DATE OF DEATH | | DECEASED'S TIME OF DEATH | | DECEASED'S PLACE OF DEATH | | CITY | | COUNTY | |
| FEB 1 1958 | | 10:00 PM | | BALTIMORE, MD. | | BALTIMORE | | BALTIMORE | |
| DECEASED'S CAUSE OF DEATH | | DECEASED'S MANNER OF DEATH | | DECEASED'S PLACE OF DEATH | | CITY | | COUNTY | |
| SUICIDE | | SUICIDE | | BALTIMORE, MD. | | BALTIMORE | | BALTIMORE | |

BUREAU V. 8

FEB 1 1958

RECEIVED